MAITLAND PSYCHOLOGY, P.A.

Clinical Psychology
Clinical Neuropsychology

AUTHORIZATION TO OBTAIN OR RELEASE PROTECTED HEALTH INFORMATION

By signing this Authorization, I hereby authorize and permit the use and/or disclosure of my protected health information (medical record) for the limited purpose(s), and in the limited manner, described in this form. In addition, I understand that this Authorization is completely voluntary and I am signing it under my own free will.

Patient Name: _____ **Date of Birth:** _____

I authorize my psychologist **Dano A. Leli, Ph.D, Rebecca C. Villar, PsyD, Antoneal Swaby, PsyD, M.Ed., Kristin Mickel, PsyD**, and/or his administrative and clinical staff to _____**DISCLOSE to and/or** _____**OBTAIN from:**

_____
Name of Facility or Person

the following information contained in my medical record regarding my care and treatment:

____ Complete Medical Record
____ Therapy Records
____ Evaluation/Consultation Reports
____ Billing Summary
____ Verbal exchange of information
____ All Diagnostic Test Results
____ Other _____

I am requesting my psychologist to release or obtain this information for the following reasons:

_____ at the request of the patient or representative _____ coordination of care/continuity of care

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, alcohol, and/or drug abuse, HIV testing, AIDS diagnoses, eating disorders information or any other records of a sensitive nature.

This Authorization shall remain in effect until **ONE YEAR FROM THE DATE OF SIGNATURE.**

I understand that I may revoke this authorization at anytime by notifying this office in writing. However, I understand that it will not effect any actions taken before receiving the revocation, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and may no longer be protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient/Legal Guardian Date

_____ _____
Witness Date

500 N. Maitland Avenue, Suite 110 Maitland, FL 32751
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